CHAPTER NO. 276

SENATE BILL NO. 1451

By Atchley, Crowe, Herron, McNally

Substituted for: House Bill No. 1535

By Kisber, Hargrove, McDaniel, Walker, Caldwell, Sherry Jones, Maddox, Eckles, Hood, Stulce, David Davis, Montgomery, White, Hagood, Langster, Beavers, Pleasant, Hargett, Newton, Black, Bone, Davidson, West, Buttry, Pinion, Odom, Ralph Cole, Kent, McMillan

AN ACT To amend Tennessee Code Annotated, Section 56-32-226 and Title 71, Chapter 5, to establish procedures ensuring the prompt payment of provider claims submitted to health maintenance organizations and behavioral health organizations engaged in a TennCare line of business.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-32-226, is amended by renumbering the first paragraph as subsection (a) and adding the following new subsection:

(b) This subsection is intended to ensure the prompt and accurate payment of all provider claims for services delivered to an enrollee in the state's TennCare Program which are submitted to a health maintenance organization involved in a TennCare line of business or a subcontractor of that organization. Accordingly, each such organization or subcontractor must establish and implement the following procedures for the processing of provider claims and the resolution of any disputes regarding the payment of such claims:

(1) The health maintenance organization shall ensure that ninety percent (90%) of claims for payment for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) days 99.5% of all provider claims for services delivered to an enrollee in the state's TennCare Program. The term "process" means the health maintenance organization must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation. The term "pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.

(2) If a provider's claim is partially or totally denied in a remittance advice or other appropriate written notice, then the provider may send a written request for reconsideration to the health maintenance organization within sixty (60) days of the receipt of the partial or total

denial of the claim. The reconsideration request should include any documentation or information requested by the health maintenance organization. The health maintenance organization must respond to the reconsideration request within sixty (60) days after receipt of the request. If the health maintenance organization continues to deny the provider's claim or the health maintenance organization does not respond within sixty (60) days of receipt of the request, then the provider may file a written request to submit the claims denial to an independent reviewer for review as provided herein at subdivision (3).

(3) Each health maintenance organization operating a TennCare line of business must contract with independent reviewers selected in accordance with subdivision (4) below, and implement the following procedures to resolve disputed provider claims:

(A) When the commissioner receives a written request for review of a disputed provider claim, the commissioner shall refer the claim for review to an independent reviewer on the health maintenance organization's contracted reviewer panel. Each contracted reviewer shall be referred an equal proportion of total annual disputed claims. The reviewer shall, within ten (10) working days of receipt of the disputed claim, request in writing that both the provider and the health maintenance organization provide the reviewer any and all information and documentation regarding the disputed claim. Such information or documentation must be received within thirty (30) days of receipt of the reviewer's request or will not be considered by the reviewer. The reviewer shall also advise the provider and health maintenance organization to identify all information and documentation that has been submitted by the provider to the health maintenance organization regarding the disputed claim. The reviewer shall then examine all material submitted and render a decision on the dispute within sixty (60) days of receipt of the disputed claim, unless the reviewer requests guidance on a medical issue from the TennCare Appeals Unit in the Tennessee Department of Health. In reaching a decision, the reviewer shall not consider any information or documentation from the provider that the provider did not submit to the health maintenance organization during that organization's review of the provider's disputed claim.

(B) Should the reviewer need assistance on a medical issue connected with the disputed claim, then the reviewer shall refer this specific issue for review and response to the person in charge of the TennCare Appeals Unit, unless the Department of Health in writing designates a different contact. Medical issues requiring referral may include whether a medical benefit is a covered service under the state's TennCare Contract. The TennCare Appeals Unit may respond to the request, or refer the request to an

independent contractor or the TennCare Bureau for review. A request to determine whether a service received was medically necessary must be responded to by a physician licensed by one or more states in the United States. The Appeals Unit shall provide a concise response to the request within ninety (90) days after it was received. If the Appeals Unit seeks the guidance of the TennCare Bureau on whether a benefit is a covered service, then the Bureau must respond to that request in writing in sufficient time to allow the Appeals Unit to timely respond to the reviewer. The reviewer shall make a final decision within thirty (30) days of receipt of the Appeals Unit's response.

(C) The reviewer shall send both the health maintenance organization and the provider a copy of the decision. Once the reviewer makes a decision requiring a health maintenance organization to pay any claim or portion thereof, then the health maintenance organization must send the payment in full within twenty (20) days of receipt of the reviewer's decision.

(D) Within sixty (60) days of a reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the reviewer's decision and to recover any funds awarded by the reviewer to the other party. Any claim concerning a reviewer's decision not brought within sixty (60) days of the reviewer's decision will be forever barred. Suits filed pursuant to this section will be conducted in accordance with the Tennessee Rules of Civil Procedure, and the review by the court will be de novo without regard to the reviewer's decision. The reviewer, or any person assisting the reviewer in reaching his or her decision, shall be prohibited from testifying at the court proceeding considering the reviewer's decision. Unless the contract between the parties specifies otherwise, venue and jurisdiction will be in accordance with Tennessee law. If the dispute between the parties is not fully resolved prior to the entry of a final decision by the court initially hearing the dispute, then the prevailing party shall be entitled to an award of reasonable attorney's fees and expenses from the non-prevailing party. Reasonable attorney's fees means the number of hours reasonably expended on the dispute multiplied by a reasonable hourly rate, and shall not exceed ten percent (10%) of the total monetary amount in dispute or five hundred dollars ($500), whichever amount is greater.

(E) If a provider does not file a written request for the commissioner to submit the partial or total denial of a claim to an independent reviewer, then the provider may pursue any appropriate legal or contractual remedy available to the provider to contest

the partial or total denial of the claim. For all claims filed on or after October 1, 1999, the state shall not, through its TennCare contract or otherwise, require any specific claims dispute resolution process between providers and health maintenance organizations other than the independent review process described above. Any provision in the state's current TennCare contract providing otherwise shall be of no effect for provider claims filed on or after October 1, 1999, or for filed provider claims that are disputed as of September 30, 1999, and have not been submitted to arbitration.

(F) The above procedures shall apply to providers who are owned by state or local governmental entities, except that such providers shall retain the statutory right of setoff if available. Accordingly, TennCare claims disputes between state or local governmental providers and health maintenance organizations may be resolved by reference first to an independent reviewer, with judicial review of the reviewer's decision, or any claim denial, sought in the Davidson County Chancery Court, and not the Tennessee Claims Commission, in accordance with subitem (D) and (E) above unless the parties have agreed to another appropriate venue and jurisdiction by contract. This subitem does not impact any claim of sovereign immunity that a state or local governmental provider may possess, although such a provider will be responsible for paying any appropriate attorney's fees and expenses awarded under subitem (D) above.

(G) All costs associated with implementing these procedures shall be paid by the applicable health maintenance organization. However, the provider shall reimburse the health maintenance organization the independent reviewer's fee for resolving the claims dispute if the reviewer finds that the health maintenance organization properly denied the claim being reviewed.

(H) The health maintenance organization shall pay any appropriate bill submitted by an independent reviewer within thirty (30) days of receipt of the bill. If the health maintenance organization fails to pay any such bill, then the reviewer may request payment directly from the state from any funds held by the state that are payable to the health maintenance organization.

(I) The above procedures shall apply to all claims filed after September 30, 1999. However, a provider or a TennCare health maintenance organization may elect to immediately seek judicial review of any claims dispute existing as of September 30, 1999, that has not been referred to arbitration. This

request for judicial review must be filed within the time frames required by applicable Tennessee law.

(J) By September 15, 1999, each health maintenance organization shall submit evidence satisfactory to the commissioner that these independent review procedures will be implemented on or after October 1, 1999.

(4) The commissioner shall appoint a panel of five (5) persons, known as the TennCare Claims Processing Panel. The Panel shall consist of two (2) provider representatives, one (1) representative from each of the two (2) health maintenance organizations with the largest number of TennCare enrollees as of June 1, 1999, and the deputy commissioner of the TennCare Division in the Department of Commerce and Insurance. If either of the largest health maintenance organizations declines to serve, the commissioner shall select another TennCare health maintenance organization to serve. All decisions of the Panel shall be made by a majority vote of the members of the Panel. The Panel shall select and identify an appropriate number of independent reviewers to be retained by each health maintenance organization under subdivision (3) by no later than August 13, 1999. The Panel shall negotiate the rate of compensation for each reviewer, and the rate of compensation shall be the same for each reviewer. Each health maintenance organization engaged in a TennCare line of business, as a condition of participating as a contractor in the state's TennCare program, shall contract with each reviewer and agree to pay the rate of compensation negotiated by the Panel. The Panel shall also conduct a study, with the assistance of staff from the Department of Commerce and Insurance and the Department of Health, to assess whether the state should require uniform claims processing requirements for the health maintenance organizations participating in the state's TennCare Program. This study shall be completed and provided to the commissioner and the director of the TennCare Bureau by no later than March 31, 2000. The expenses of this Panel shall not be compensated by the state.

(5) By no later than May 1 of each year, the commissioner shall report to the Department of Health and to the Joint Fiscal Review Committee the number of requests for TennCare claims review filed for each health maintenance organization operating a TennCare line of business during the prior calendar year. The commissioner shall also generally report the outcome of these adjudication requests for each health maintenance organization, and shall report the name of any provider that loses more than fifty percent (50%) of submitted claim reviews as well as the number of claim reviews lost by that provider.

(6) All claims for services furnished to a TennCare enrollee filed with a health maintenance organization must be processed by either the health maintenance organization or by one (1) subcontractor retained by the organization for the purpose of processing claims. However, another entity can process claims related to pharmacy, vision, dental or mental health benefits. This subdivision shall be effective January 1, 2001.

(7) The health maintenance organization shall ensure all subcontractors processing TennCare claims for health maintenance organizations follow the same claims processing and resolution

procedures required by Tennessee Code Annotated, Section 56-32-226(b).

(8) A health maintenance organization that subcontracts with another entity to obtain a network of providers to furnish services to TennCare enrollees shall guarantee and assure the payment of all contracted amounts agreed to be paid to such providers by that entity or that entity's agent. This subdivision does not preclude the health maintenance organization from seeking reimbursement from the subcontractor for any amounts paid pursuant to this subdivision. Nor does this subdivision prevent the health maintenance organization from asserting any legal defenses to the payment of a provider's claim that were available to the subcontractor. This subdivision shall be effective for all provider claims for TennCare services delivered after January 1, 2001.

(9) If a provider agreement requires compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, then such payment shall be made by either the time specified in the provider's contract or by the tenth day of each calendar month.

(10) Any health maintenance organization found by the commissioner to be in violation of Section 56-32-226(b) shall be subject to revocation or suspension of its certificate of authority under Section 56-32-216 or in the alternative the imposition of the penalties and other remedies set forth at Section 56-32-220.

SECTION 2. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding a new section stating as follows:

Section 71-5-___. This section is intended to ensure the prompt and accurate payment of all claims incurred by providers delivering services to enrollees of the state's TennCare Partners Program, and to formalize the resolution of all claims disputes arising under the Partners Program. Accordingly, the standards and requirements set forth at Tennessee Code Annotated, Section 56-32-226(b), shall be applicable to the TennCare Partners Program. Specifically, all entities contracting with the state in the Partners Program shall have the same rights and obligations as defined for TennCare health maintenance organizations at Tennessee Code Annotated, Section 56-32-226(b). The Commissioner of the Department of Commerce and Insurance shall have the authority to conduct periodic examinations of these entities to verify compliance with this section. Any entity found to be in noncompliance with this section shall be subject to the imposition by the Commissioner of Commerce and Insurance of the same penalties and other remedies set forth at Tennessee Code Annotated, Section 56-32-220.

SECTION 3. Except as otherwise provided by the provisions of this act, any costs associated with implementing the provisions of this act shall be paid for with funds that have been appropriated for purposes of administering the TennCare program.

SECTION 4. If any provision of this act, or the application thereof, to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 5. Unless otherwise previously stated, the provisions of this act shall take effect upon becoming a law, the public welfare requiring it.

PASSED: May 24, 1999

JOHN S. WILDER
SPEAKER OF THE SENATE

JIMMY NAIFEH, *SPEAKER*
HOUSE OF REPRESENTATIVES

APPROVED this 26th day of May 1999

DON SUNDQUIST, GOVERNOR